

August 30, 2002

Re: Medical Dispute Resolution  
MDR #: M2-02-0932-01  
IRO Certificate No.: I RO 5055

Dear

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to \_\_\_\_ for an independent review. \_\_\_\_ has performed an independent review of the medical records to determine medical necessity. In performing this review, \_\_\_\_ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician Board Certified in Pain Management.

**The physician reviewer DISAGREES with the determination made by the insurance carrier in this case. The reviewer is of the opinion that trigger point injections are medically necessary in this case.**

I am the Secretary and General Counsel of \_\_\_\_ and I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

We are forwarding herewith a copy of the referenced Medical Case Review with reviewer's name redacted. We are simultaneously forwarding copies to the patient, the payor, and the Texas Workers' Compensation Commission. This decision by \_\_\_\_ is deemed to be a Commission decision and order.

#### **YOUR RIGHT TO REQUEST A HEARING**

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

**If disputing a spinal surgery prospective decision** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **ten (10)** days of your receipt of this decision (28 Tex. Admin. Code 142.5©).

**If disputing other prospective medical necessity (preauthorization) decisions** a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **twenty (20)** days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5)** days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
Texas Workers' Compensation Commission  
P.O. Box 40669  
Austin, TX 78704-0012

**A copy of this decision should be attached to the request.** The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

**I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 10<sup>TH</sup> day of July 2002.**

Sincerely,

### **MEDICAL CASE REVIEW**

This is for \_\_\_\_\_. I have reviewed the medical information forwarded to me concerning TWCC Case File #M2-02-0932-01, in the area of Pain Management. The following documents were presented and reviewed:

A. MEDICAL INFORMATION REVIEWED:

1. Request for review of denial of trigger point injections.
2. Correspondence.
3. History and physical and office notes.
4. Operative reports.
5. Radiology reports.

B. BRIEF CLINICAL HISTORY:

The patient is a 47-year-old female who was involved in a work-related accident in which she sustained an injury to her left shoulder, neck and lower back. She has been treated for this injury to her shoulder and neck and, most significantly, treated for her lower back pain with a spinal cord stimulator. A request was made by \_\_\_\_ for trigger point injections in the

left shoulder area for symptomatology consistent with myofascial pain syndrome.

C. DISPUTED SERVICES:

The trigger point injections were denied based on the fact that the patient has not been treated for years in this area, and it is felt that this myofascial pain syndrome presenting at this time is not related to her compensable injury because of the lack of active treatment over the years.

D. DECISION:

I DISAGREE WITH THE DETERMINATION MADE BY THE INSURANCE CARRIER IN THIS CASE.

E. RATIONALE OR BASIS FOR DECISION:

The reason for my disagreement is that there is clearly a note in the chart from approximately one year ago where \_\_\_\_ did treat the shoulder in question. There are also numerous notes indicating she has had problems over the years. A severe capsulitis in the shoulder is likely to result in decreased range of motion which would make this patient susceptible to myofascial pain syndrome for an extended period of time following the injury, potentially even a lifetime. Trigger points in the area are a normal occurrence of this type of restriction, and trigger point injections are well within the scope of reasonable medical care for this problem.

F. DISCLAIMER:

The opinions rendered in this case are the opinions of this evaluator. This medical evaluation has been conducted on the basis of the documentation as provided to me with the assumption that the material is true, complete and correct. If more information becomes available at a later date, then additional service, reports or consideration may be requested. Such information may or may not change the opinions rendered in this evaluation. My opinion is based on the clinical assessment from the documentation provided.

Date: 26 August 2002